MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Tenet Healthcare/RHD Medical Center 2401 Internet Blvd., #110 Frisco, TX 75034	MDR Tracking No.: M4-05-3414 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Hartford Underwriters Ins./Rep. Box #: 27 300 S. State St. One Park Plaza Syracuse, N.Y. 13221	Date of Injury: Employer's Name: Volt Information Sciences Inc. Insurance Carrier's No.: 690C 27242

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
2-25-04	2-28-04	Inpatient Hospitalization	$26,925.12	$00.00

PART III: REQUESTOR'S POSITION SUMMARY

Position statement of December 22, 2004 states in part "…we have reviewed the claim and payment for the above hospital admission. Our findings reveal this claim has not been pain according to the hospital fee guideline… in reviewing payments on this account, it appears implants were carved out and only denied for invoices and only 3 days were allowed at the TWCC per diem rate of $1118 for a total payable of $3354. No consideration was given that this was a Stoploss claim. TWCC hospital fee guidelines, per the stoploss methodology, does not have any carve outs (such as implants) that pay at a different rate than the rest of the claim… We are requesting proper reimbursement per the stoploss clause of the TWCC hospital fee Guidelines at 75% billed (audited) charges…"

PART IV: RESPONDENT'S POSITION SUMMARY

Position statement of February 16, 2005 states in part "… the purpose of the stop loss method is to ensure fair and reasonable reimbursement. Two of the criteria that must be met to establish entitlement to stop loss reimbursement are 1. Audited charges in excess of $40,000, and 2. The services provided should be UNUSUALLY EXTENSIVE/COSTLY. Also, all methods of determining reimbursement must meet the statutory requirements set forth in the Texas Labor Code Sec. 413.011(d)… It is the Carrier's position that they have correctly reimbursed the provider using the per diem methodology and no additional reimbursement should be made".

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

This dispute relates to inpatient services provided in hospital setting with reimbursement subject to the provisions of Rule 134.401 (Acute Care Inpatient Hospital Fee Guideline). The hospital has requested reimbursement according to the stop-loss method contained in that rule. Rule 134.401(c)(6) establishes that the stop-loss method is to be used for "unusually costly services." The explanation that follows this paragraph indicates that in order to determine if "unusually costly services" were provided, the admission must not only exceed $40,000 in total audited charges, but also involve "unusually extensive services."

After reviewing the documentation provided by both parties, it does **not** appear that this particular admission involved "unusually extensive services." The UB-92 lists the "Prin Diag 996.78"; due to other internal orthopedic device, implant, and graft. Accordingly, the stop-loss method does not apply and the reimbursement is to be based on the per diem plus carve-out methodology described in the same rule.

The total length of stay for this admission was 3 days (consisting of 3 days for surgical). Accordingly, the standard per diem amount due for this admission is equal to $3,354.00 (3 times $1,118). In addition, the hospital is entitled to additional reimbursement for (implantables/MRIs/CAT Scans/pharmaceuticals) as follows: However, the requestor did not submit any medical documentation that the surgery involved unusually extensive services nor did the requestor submit any implant invoices; therefore, MDR cannot determine the cost plus 10%.

Considering the reimbursement amount calculated in accordance with the provisions of rule 134.401(c) compared with the amount previously paid by the insurance carrier, we find that no additional reimbursement is due for these services.

PART VI: COMMISSION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings and Decision by:

	Roy Lewis	4-25-05
Authorized Signature	Typed Name	Date of Decision

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, 7551 Metro Center Drive, Suite # 100, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____